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Social Support and Depressive Symptoms of Older Adults Residing in an Age Segregated Housing Complex

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SOCIAL SUPPORT AND DEPRESSIVE SYMPTOMS OF OLDER ADULTS RESIDING IN AN AGE SEGREGATED HOUSING COMPLEX

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CERTIFICATE OF APPROVAL

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ABSTRACT

SOCIAL SUPPORTS AND DEPRESSIVE SYMPTOMS OF OLDER ADULTS RESIDING IN AN AGE SEGREGATED HOUSING COMPLEX

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Research regarding social supports and depression has been extensive with the older adult population except for areas of mid-sized communities ranging between 25,000 to 75,000. This was an exploratory, cross-sectional study examining the social supports and depressive symptoms of older adults residing in an age segregated housing complex in a Midwest city with a population under 35,000. The participants (N=8), were residents of an age segregated public housing complex. Through the completion of a scheduled-standardized interview, the participants answered forty-two questions from the Duke Social Support Index and the Geriatric Depression Scale. The questions were based on current mood level and their social network interactions within the past week of the interview. General systems theory and social support theory were used to identify the relationships of family and friends with the older adult's level of depression. Past research indicates social support decreases the level of depression in the older adult with the age of the participants not warranting any substantial difference in results. Program implications of these findings include: an effective understanding of depression and its relationship to social supports, the importance of lobbying for the needs of the older adults and being an advocate at a community level.

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CHAPTER 1

Introduction

This chapter identifies issues surrounding depression and social supports of older adults in an age segregated housing complex. The statement of the problem, background of the problem, purpose and significance of this research study are identified and the chapter concludes with the research questions.

Statement of Problem

Decreases in social interactions are in part due to the perception of how older adults are aging, the support of family or social service agencies, or the perceived physical or social decline by associating with other frail older adults in an age segregated housing complex (Sheehan, 1986). As their social interactions begin to decline, the emotional well being of the older adult is inhibited, thus creating feelings of being isolated and lonely; allowing the development of depressive symptoms to surface. Depressive symptoms increase when older adults residing in an age segregated housing complex have few social contacts, no one to confide in, and typically spend the day alone (Bijur, Kelman, Kennedy, Metz, Thomas, & Wisniewski, 1989).

The level of support and the symptoms of depression reported by each individual interviewed were examined in this research study. In this researcher's experience, symptoms of depression in older adults in a public housing unit fluctuate varying on the support they receive from friends and family. This research paper examined the importance of support networks and the way older adults view themselves and their current surroundings.

Background of the Problem

Families play an integral part in assisting an older adult in coping with depression. The family, neighbors, and close friends of an older adult with depression or who shows signs of depression, begin to recognize changes within patterns of communication, and begin to identify when patterns change in mood or behavior. These social supports provided by family and friends can buffer the symptoms of depression. When support is strong, it is an important predictor of good physical and mental health, life satisfaction, and a reduction in cases of institutionalization among older adults (Newsom & Schulz, 1996; Potts, 1997; Rogers, 1999).

According to Adams (1985-1986) and Potts (1997), there is a direct correlation between the levels of outside friend contacts and the rate of depression. The composition of the social supports for older adults who live alone is increasingly comprised of friends rather than family (Thompson & Krause, 1998). Grant, Patterson, and Yager (1988) believed that the support of friends is important, but that the support of the family would become the most important asset in the improvement of health changes. The supportive roles of a family are considered to be obligatory, while the role of a friend is commonly voluntary (Thompson & Krause, 1998).

A decrease in social function of older adults is commonly associated with lower levels of perceived support. Diminished family and friend contacts, a decline in feeling as though they belong, and a decrease in providing material assistance to others is consequential factors leading to depressive symptoms (Newsom & Schulz, 1996). Remission of depression is characterized by changes in social support, unwanted life

events and decline in physical health (Bijur, Kelman, Kennedy, Metz, Thomas, & Wisniewski, 1989).

Purpose and Significance of Research Study

The purpose of this research study was to explore how social support networks impacts depressive and isolative characteristics displayed by older adults in an age segregated housing complex in the Midwest. The participants in this study were asked questions to measure their level of formal and informal social support and their current level of depression in order to formulate a connection between these variables.

The findings of this study and of previous research will allow future practitioners to identify the social interactions of an older adult that have an effect on their level of depression and the benefits of formal and informal interactions on an older adult's life. It will give practitioners alternative ways of looking at finding solutions and identifying effective resources to continue to find healthy, interactive lifestyles for the older adult.

Recent studies that examine depression and social support regarding older adults in an age segregated housing complex are completed in cities with a population over 100,000. This study was completed to examine whether the relationship of social support and depression in a city located in the Midwest with a population under 35,000 varied in comparison to previous studies conducted in a city with a population over 100,000.

Research Questions

This research study explored the following questions:

1. What is the relationship between the level of social supports and depression in older adults in an age-segregated housing complex?
2. What is the availability of social supports provided to the older adults (as perceived by the older adult)?

CHAPTER 2

Literature Review

This chapter examines literature on the effects of depression on the structure of the current age segregated housing complexes in regards to social interaction, social support, psychosocial factors, physical factors, and the mental health services offered to these complexes. Some effective methods of reaching older adults with depression are discussed in relation to social supports. Identified gaps within the literature are discussed.

Social interaction in age segregated housing complexes

The rate of depression within older adults in housing units is significantly higher compared to the community at large (Black, German, McGuire, Rabins, & Roca, 1997). The intended creation of age-segregated housing was to promote healthy interactions between individuals who shared the same interests. In some cases, age segregated housing may cause isolation from the extended community (Potts, 1997).

The concept of age-segregated complexes has both negative and positive impacts on the emotional well being of an older adult. Older adults seek age segregated housing complexes to escape feelings of loneliness or create new social interactions with others; however, this may create apprehensive feelings related to the unknown and lead to confining themselves to their apartment (Bernstein & Stephens, 1984).

One of the positive aspects of age-segregated housing is that it enhances the development of close friendships with people of the same age group with individuals who possess some of the same interests (Adams, 1985-86). The personality of the older adult influences the way in which they interact with others. Withdrawn and reclusive older

adults avoid crowded areas and prevent giving any personal information to other individuals. They stay in their apartment and avoid making any close connections to others living in the building. These older adults tend to develop symptoms of loneliness, sadness, and depression.

Decreases in social interactions are in part due to their perception of how they are aging, the support of family or social service agencies, or the perceived physical or social decline by associating with other frail older adults in the complex (Sheehan, 1986). As their social interactions begin to decline, the emotional well being of the older adult is inhibited, thus creating feelings of isolation, loneliness, and the progressive development of depressive symptoms. Depressive symptoms increase when tenants have few social contacts, no one to confide in, and when they typically spend the day alone (Bijur, Kelman, Kennedy, Metz, Thomas, & Wisniewski, 1989).

Social Support

The Role of Social Support in Relation to the Problem

As an older adult continues to age, the depleting relationships of friends and families along with the decreasing opportunities to develop new relationships increases the chance of loneliness developing into depression (Mullins & Dugan, 1990). However, the perceived social support of the older adult has a stronger effect on health and well being than received support (Thompson & Krause, 1998).

If they perceive their support as inadequate, a longer duration of depressive illness exists (Fukunishi, Aoki, & Hosaka, 1997). The duration of depression is influenced by their gender and marital status. Significant differences are found amongst gender and

marital status when they identify how their perceived support is providing personal care, instrumental, and emotional needs (Stolar, MacEntee, & Hill, 1993).

In most cases, older adults prefer their needs to be met by family members rather than professionals or friends due to the personal nature of their problems (Bookwala, Newsom, & Schulz, 1997). The solidarity of familial support solidifies the bonds of meaning, experience, independence, and affection (Mullins, 1991).

Older adults typically live near one adult child and interact frequently with this child through mutual aid (Mullins, 1991); therefore becoming major providers of assistance (Mullins & Dugan, 1990; Bernstein & Stephens, 1984). On the other hand, older adults who never had children are more likely to live alone, have a decreased level of social interaction, and are likely to have minimal, if any social contact in the past day or so (Mullins, 1991; Hyduk, 1996; Mullins & Dugan, 1990).

The interaction an older adult has with friends creates a positive influence on the morale of the individual (Mullins & Dugan, 1990). In some cases, the support system of family and friends may complete the desired social interaction in a timely manner, but injures the self-esteem of the older adult, by creating an unhealthy dependency on their family (Wallsten, Tweed, Blazer, & George, 1999).

The Response of Social Supports to the Problem

When working with a family of a depressed older adult, the first determinant examined is existing relationships between family members. Each family communicates and relates differently to each of its members in order to achieve their own goals. By using the object relations theory, the presentation of an individual is created from the continual interactions they have within their environment as a child, which directly

relates to the influence of their mother (Hernandez, Hinrichsen, & Lapidus, 1998). Early parental influences determine the parent and child relationships later in life. When a higher level of object relations as a child is distinguished, then it can be predicted that they cope and adjust better in stressful situations. On the other hand, an adult child of a depressed parent may become over involved, have a difficult time relating to their illness, or condemn and belittle their parent due to their inability to understand that depression reflects poor object relations (Hernandez, Hinrichsen, & Lapidus, 1998).

Friends and family may remove themselves from contact with the older adult because they view the depressed individual as a burden (Newsom & Schulz, 1996). Family or friends may withdraw due to their lack of knowledge about the illness or their inability to recognize the problem exists. Without this social support, an older adult has a difficult time recovering from depression. In some situations, the social supports found in family and friends no longer exist due to death or relocation. The diminishing social supports of the older adult are the result of the natural process of aging (Newsom & Schulz, 1996).

One way the family may cope with a depressed older adult is to become overly involved. Frequent observations by practitioners recognize that some family members become overly involved with the older adult to the point that their lives are enmeshed (Hernandez, Hinrichsen, & Lapidus, 1998). In cases where this occurs, the caregiver often refuses any help from others. This caregiver burden not only affects the relationship between the caregiver and older adult, but also has an impact within the family of the caregiver (Adamson, Caserta, Feinauer, & Lund, 1992). The relationships created between social supports and the depressed older adult creates an abundance of

problems relating to the persistence of the older adult in regards to their demands (Grant, Patterson, &Yager, 1988).

Working with the Social Supports for Treatment Planning

In certain cases, clinicians use family members to help uncover depression (Reynolds III, 1995). Family members provide a practitioner with insights to problems the older adult may not want to discuss. Older adults do not willingly disclose prior episodes of family depression, suicide, or other mental illnesses.

Family members can assist their loved one by participating in a conjoint interview. By involving the family in this process, the family learns about depression, the treatment process, and the symptoms related to depression (Reynolds III, 1995). When the practitioner uses the family in the decision-making process, the family not only learns how to help their loved one, but also educates them about treating depression and recognizing symptoms of depression.

In an open system of social support, a professional works to strengthen the informal supports existing and examines the interests of the older adult in comparison to the social support needs. Professionals work with the social supports to develop and affirm their feelings of love and support to the depressed older adult. Social supports in an open system are strong and focus on the betterment of the depressed individual.

Psychosocial Factors

Predominant stressors adversely affecting the older adult relate to the "fear or actual loss of a loved one, loss of social and economic status by retirement, and realization of mortality because of the illness and death of siblings and/or

contemporaries" (Jenkins, Salloway, & Westlake, 1996, p. 340). Dwelling on trivial physical or emotional problems prevail and substantiate the prolongation of depression.

Interpersonal and social problems along with a decreased enjoyment of pleasurable activities become affected by the symptoms of depression (Burnette & Mui, 1994). Depressed older adults become isolative and lonely. They perceive they cannot be helped, thus dwelling on the negative aspects of their lives. Continual disruptions such as death, demoralization, loss of independence onsets the risk factors of substance use, depression, or medical disorders (Burnette & Mui, 1994).

When an older adult becomes depressed or lonely, their task of completing their activities of daily living closely equal the level of older adults who have a chronic illness, but combined, depression can elevate the level of the chronic illness (Burnette & Mui, 1994). As their depression level increases, the older adult loses control of their independence, their self-confidence and their ability to find happiness in their life.

Physical factors

With the onset of depression, the chance of physical decline increases in older adults (Deeg, Ferrucci, Guralnik, Penninx, Simonsick, & Wallace, 1998). In some cases, "physical disorders are recognized as depression (hypothyroidism, pancreatic cancer), physical symptoms can be manifestations of psychiatric disorders (sleep and appetite disturbances), and depression can be a reaction to a physical disorder (Alzheimer's disease) or even the environment in which one is being treated" (Drozdick, Edelstein, Kalish, McKee, & Whipple, 1999, p. 19). In order to properly diagnose an older adult with depression or with a chronic illness, a list of their problems and symptoms should be compiled.

The symptoms of depression increase as the older adult ages, remains single their whole live, or if they have a lower educational level, and physical issues such as coronary or lung disease exist (Deeg, Ferrucci, Guralnik, Penninx, Simonsick, & Wallace, 1998). The rate of their action varies depending upon their willingness to perform activities.

Mental Health Services

The older adults who suffer from depression not only have the obstacles of their illness, but the lack of recognition of their illness by professionals. Mental health services pertaining to the older adult population are largely ignored by policy makers, service providers and educators (Reynolds III, 1995; Carner, Klein, & Waxman, 1984). Professionally defined, the older adult's needs continue to be disregarded because consumers do not recognize their mental health needs (Black, German, McGuire, Rabins, & Roca, 1997). By not offering services to the older adults, their mental health needs go unanswered.

The signs of depression are commonly attributed to the normal process of aging or other co-morbid conditions (Harman & Reynolds III, 2000). Older adults seek medical help for somatic symptoms such as poor sleep patterns, chronic pain, or migraine headaches, which results in the misdiagnosis of the real problem of depression (Jenkins, Salloway, & Westlake, 1996). In some cases, older adults do not acknowledge the fact that they have a mental health problem (Black, German, McGuire, Rabins, & Roca, 1997).

When depression is unrecognized and untreated, it can cause significant morbidity and even mortality in older adults (Reynolds III, 1995). The physical and emotional effects of depression can range from a mild form of disturbed sleep patterns to neglected

personal cares, accumulated clutter in their living arrangements, or low mood most of the day. With the under recognition of depression, effective screening methods appear to be essential (Allen, Lewisohn, Roberts, & Seeley, 1997).

Older adults lack knowledge about mental health services in their community. By combining the lack of knowledge about mental health services and how to access them with the lack of routine contact with mental health professionals, the limited use of mental health services can be examined (Abraham, Neese, Snustad, & Thompson-Heisterman, 1993; Klenow & Rokke, 1998). By knowing assistance is available such as emotional support or information assistance, a sense of security becomes a significant aspect in maintaining a positive well being (Newsom & Schulz, 1996).

Individuals possessing strong social supports are less likely to seek mental health services when they experience emotional problems (Murrell & Phillips, 1994). It is not necessarily the significance of social supports in determining the use of mental health services, but it is the level of how the relationships were viewed when support and help were needed.

Literature Gaps

Few studies examined the differences in the use of social support between women and men. Women tend to live longer than men, and they are perceived as adjusting and coping with the lack of social supports better than men. Further studies should emphasize the gender differences in the utilization of social supports.

Few studies have been conducted examining the aspects of social support and depression together in a city with a population under 35,000. In this study, these aspects were examined together to understand if the social support level of the older adult can

increase the likelihood of depression. Studies have identified that the lack of social supports can cause depression, but these studies do not examine the role of social support and the development of depression in a rural setting.

CHAPTER 3

Theoretical Framework

The issue of social support in depressed older adults residing in an age segregated housing complex is best examined using the general systems theory and social support theory. By identifying the different dimensions of how social support is affected by the interactions an individual has with their environment or other people, the emotional well being of the older adult changes in relation to these interactions.

General System Theory

When examining systems theory, the main principle guiding the direction of a social worker depends on their client's environment, thus relating to the client's satisfaction of life. The main systems affecting life satisfaction are the informal or natural system, formal system, or societal systems. By further examination, the social connections a client has within these systems in relation to their environment affect the way in which a client functions on a regular basis (Payne, 1997).

Within the structure of the family system, rules and roles guide the family's interactions. Rules determine what each individual within the system is permitted to do in order to regulate the behavior of each member and how the project their emotions onto others. The rules that each member has within the system are determined by the dynamics, external influences, and the time in which things are completed. The concepts of roles can be broken down further by role continuity, role competency, role ambiguity, and role conflict (Turner, 1996). These roles can be formed through collaboration, bargaining amongst them, or conflict varying on the relationships previously developed in this system (Payne, 1997).

Systems influencing an individual are created by the behavior of the person or the interactions they have with groups. These interactions can take place in the micro, mezzo, or macro level within the system. The approach taken using systems theory focuses on the individual's environment, social aspects, biological aspects, or cultural sources of behavior (Payne, 1997). These influences affect how the individual interacts with others in the system.

An individual acts within an open or closed system. Through interaction within an open system, an individual is able to accept outside influences to create change. Whereas in a closed system, an individual becomes isolated within their environment and will not accept any input from other systems. In most situations, an individual or family does not entirely stay within an open or closed system, but vary their interactions depending on the input they may receive (Payne, 1997).

Boundaries are created within the system to separate a family from their non-family environment. These boundaries are created to protect the uniqueness and integrity of the system and maintain which influences will enter into the system. Boundaries may be either psychological or emotional, varying on the situation. Systems have boundaries to prevent enmeshment with other systems, but also to regulate a system from disengaging. Enmeshment and disengagement may occur at the same time within a system, but very infrequently (Turner, 1996).

Concepts in Systems Theory

Within systems theory, the informal network relates to family, friends, or individuals coming in contact with the identified individual on a regular basis. The formal network is considered to be church groups, community groups, or unions. The

societal network consists of a larger entity like schools, clinics, hospitals, or housing complexes. Systems are formed at various levels and can conflict within the roles an individual has within each system (Payne, 1997).

Social Support Theory

The lack of existing social ties with others increases both the risk for poor physical or psychological health of an older adult (Seeman, Kaplen, Knudsen, Cohan, & Guralnic, 1987). Blazer (1982) found that the lack of social ties with siblings and children as well as low perceived social support from their social network were independently associated with an increase in mortality risk.

The social support system tries to create an enduring pattern of continuous or intermittent connections, thus maintaining psychological or physical integrity of the individual (Caplan, 1974). The systems that individuals are involved with affect the way people live, act and feel (Maguire, 1991). These social networks contribute to the emotional and material assistance necessary for the perceived support older adults need to survive.

Applying the Framework to the Research Problem

The relationship an older adult experiences affects their patterns of communication. An older adult may have limited contacts with others by the slow depletion of current relationships and the lack of opportunities to form new relationships (Mullins & Dugan, 1990). In most cases, older adults are heavily dependent on the family system for support, which may result in conflicts between the role of their children and extended family members.

Within the structure of a micro system, strong informal support of the older adult increases the likelihood of good physical and mental health and minimizes the stressors connected to typical aspects of aging (Potts, 1997). Without informal support of the family, the older adult typically becomes socially isolated (Bernstein & Stephens, 1984). Family systems may withdraw because they view the older adult as a burden (Newsom & Schulz, 1996). The examination of effective informal systems allows the social worker to identify the influences that a family may have and the boundaries a family system creates.

Within the macro level context of societal supports, older adults within public housing complexes tend to have casual friends or acquaintances to meet their immediate social needs (Potts, 1997; Sheehan, 1986). Short-term relationships exist when an older adult knows no one (Potts, 1997).

Within the boundaries of the family structure, disengagement occurs when family structures are unable to cope with providing long term needs to their older adults (Hyduk, 1996). The structure of the family changes to the needs of its members. When the system does not change, it disengages leaving an individual or a family without the social support they need. The emotional support, informational support, integration, and tangible help are essential aspects of social support (Krause & Markides, 1990). Families' fear becoming overly involved due to the perceived feelings of dependency and enmeshment the older adult may experience through constant involvement and completion of regular tasks from family members (Potts, 1997).

Within the structure of the family system, the increase in the perceived social support influences the effects of the development of depressive symptoms in an older

adult (Burnette & Mui, 1994). The role of family members changes as the older adult continues to age. The older adult creates a greater dependence on family members with the decline of their physical or mental health capabilities.

CHAPTER 4

Methodology

This chapter presents the methodology of this research study. This chapter contains the research questions, important concepts, units of analysis, research design, study population, population sample, measurement issues, data collection, human subjects, and data analysis.

Research Questions

This research study will explore the following questions:

1. What is the relationship of the level of social supports and depression in older adults in an age-segregated housing complex?
2. What is the availability of social supports provided to the older adults (as perceived by the older adult)?

Important concepts, units of analysis

Units of Analysis

In this study, the unit of analysis was older adults, age 55 or older residing in an age segregated complex in the Midwest. Depression was represented in this study by the feelings, emotions, or the expressions of a sad or blue state of mind. The nominal definition of social support relates to the connected feelings of belonging with their family or friends.

Operational Definitions of Social Support and Depression

In this study, *depression* was defined as an emotional reaction to life events such as; disappointment in self, significant levels of grief, negative perceptions about the future, reduction in pleasurable activities, hopelessness, and sadness (Barker, 1995). Depression was measured using the 15 item Geriatric Depression Scale (Shekh &

Yesavage, 1986). *Social Support* was defined as the advice, guidance, appraisal, and emotional support people obtain from social relationships (Ell, 1984). Social support was measured using an abbreviated 23 item Duke Social Support Index (Koening, Westlund, George, Hughes, Blazer, & Hybels, 1993).

Research Design

This was an exploratory, cross-sectional study.

Study Population

This study population was identified as older adults, age fifty-five and older, living alone, and residing in one age segregated housing complex in a Midwestern city with a population under 35,000.

Population Sample

In a rural community, credibility maybe better gained through personal contact with the researcher. This contact increases the rapport the researcher needs to establish with prospective participants. Before beginning this study, an application to the Augsburg College Institutional Review Board was completed. In this proposal, contact would be made through door-to-door contact with prospective participants. This part of the proposal was denied due to the potential coercion of participants. Instead, a letter was sent to the participants with a stamped postcard to be returned if they were interested in participating.

To obtain this sample, a letter was sent to the director of the housing complex. A short discussion of the study was scheduled with the director to ensure the safety of the individual participants. This researcher requested to interview older adults over the age

of fifty-five, with no memory impairment, and who live alone in this age segregated housing complex.

After identifying individuals over the age of 55 who live alone, 74 of the 110 residents residing at this age segregated housing complex, a table of random numbers was used to locate the initial sampling point. In order to randomly select the apartments, giving each one an equal chance, each individual was represented by their apartment number. The selection of respondents began with apartment number 203 and ending with 724, and eliminating all apartments who do not meet the study population criteria. Every third person was selected from the identified apartments until fifty respondents were identified, thus going through the available apartment numbers 2.5 times. The selected fifty individuals were presented with an envelope containing a letter that addressed the purpose of this study and a stamped postcard that would be sent back to the researcher indicating they were willing to participate in the study.

Measurement Issues

One example of random error, which relates to reliability, occurs if the older adult interprets the question differently due to the projection of the question or if they do not understand the question. One example of systematic error, which relates to validity, occurs if the older adult was unwilling to disclose their personal feelings about the relationships with their family, friends or their inability to form a relationship. Another example of systematic error relates to if the respondents were bored or tired. The answers projected in the interviewers may be biased due to their need to preserve their independence or image within the complex. The older adults could have answered the questions in a way they perceived the interviewer might have wanted them to answer. In

order to increase this study's reliability and validity, the older adults were interviewed in their apartment. It was hoped that validity and reliability was increased due to their comfort level of being in their own apartment.

Data Collection

The instruments used in this survey design consisted of the 15 item Geriatric Depression Scale (Sheikh & Yesavage, 1986) and the 23 item abbreviated version of the Duke Social Support Index (Koening, Westlund, George, Hughes, Blazer, & Hybel). Additional questions were added to achieve birth date and marital status of the respondents.

The Geriatric Depression Scale was examined to identify self-image, helplessness, and loss. The use of the Geriatric Depression Scale has acceptable reliability and validity and has the ability to differentiate between normal, mild, and severe depression (Kavan, Pace, Panterotto, & Barone, 1990).

The 23 item abbreviated Duke Social Support Index captures the essence of the original 35 item scale, providing results examining social interaction, subjective support, and instrumental support (Koening, Westlund, George, Hughes, Blazer, & Hybels, 1993).

A scheduled-standardized interview was conducted in person to ensure a specific structure for each interview. With the completion of scheduled-standardized interviews, the structure of the interview allows the interviewee to ask the same questions in the same order (DeJong, Monette, & Sullivan, 1994). These interviews consisted of thirty-six questions from both scales and an additional two questions were added relating to their birth date and marital status.

The questions used in this study consisted of nominal, ordinal, and interval measurements. The Geriatric Depression Scale used a 15 item scale consisting of nominal measurements while the Duke Social Support Index used a variety of nominal, interval, and ordinal measurements.

Respondents received a letter with a stamped postcard to return if they were interested in participating. After the postcard was sent back, an interview date was scheduled. Each interview began with brief introductions and a short conversation to ensure trust and open communication. The respondent examined the confidentiality form that described the purpose, risks, and benefits of participation. After the confidentiality form was explained to them and signed, respondents were asked if they had any further questions before proceeding. A copy of the consent form was given to each participant. Participants received two dollars as an honorarium at the beginning of the interview.

Protection of Human Subjects

An application was sent for approval of this research project to the Institutional Review Board (IRB) at Augsburg College and an approval number of 2001-31-1 was given.

All participants in this survey were informed that their participation is voluntary. A consent form needed to be signed before the interview was conducted. The consent form indicated they were invited to participate in this study. After indicating that they were over the age of 55 and lived alone, the participant read the consent form.

The consent form consisted of the background information, the procedures, the risks and benefits of being in the study, a list of telephone numbers to contact if they needed counseling services after the interview, and the voluntary nature of the study.

They were informed of the confidentiality through the participation in this study by ensuring they could not be identified and the records were kept in a locked file box. The researcher would be the only individual with access to the records and all information would be destroyed by December 31, 2001. A list of contact numbers of the researcher and the thesis advisor was given for further questions should they exist. After signing the consent form and being informed that they could discontinue the study at any time, the interview process began.

Data Analysis

This survey elicited quantitative data. These responses were sorted and related by the percentages created. Bivariate analysis was completed linking elements of depression to the identified or perceived social supports of the older adult. Figures and tables were used to identify specific areas of interest.

CHAPTER 5

Research Findings

This chapter presents the results of this study for the eight participants who were interviewed. This chapter is organized by the response rate, social demographic information of the participants, the types of social supports of the older adult as demonstrated through the Duke Social Support Index (Koening, Westlund, George, Hughes, Blazer, & Hybels, 1993), depression measured through the Geriatric Depression Scale (Kavan, Pace, Panterotto, & Barone, 1990), and the findings for the two research questions.

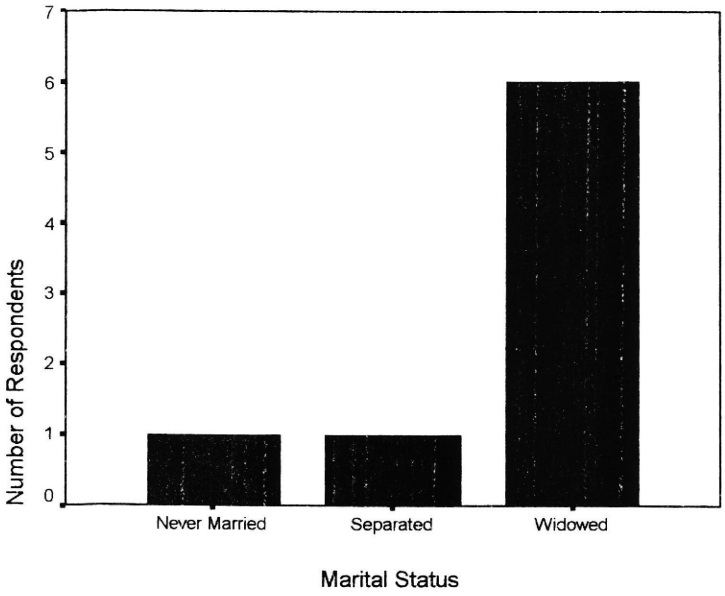
Response Rate

Fifty respondents were given an envelope consisting of a consent letter and a stamped postcard for them to return. Eight respondents (20%) were interviewed for this study with ten postcards returned. One respondent indicated they did not want to participate by sending the postcard back and writing no. Another respondent indicated they were willing to participate, but this researcher was unable to reach this respondent after five messages were left.

Social Demographics

Participants were older adults with a mean age of 80 and a median age of 76. The marital status of each participant is indicated in Figure 5.1. As displayed, two participants (25%) indicated they were never married, one was separated (13.5%), and five were widowed (62.5%).

Number 1
Figure 5.1
Marital Status of Respondents
n=8



Findings

The first research question stated the following:

1. What is the relationship between level of social supports and depression in older adults in an age segregated housing complex?

Information regarding depression and social support is presented separately and then compared.

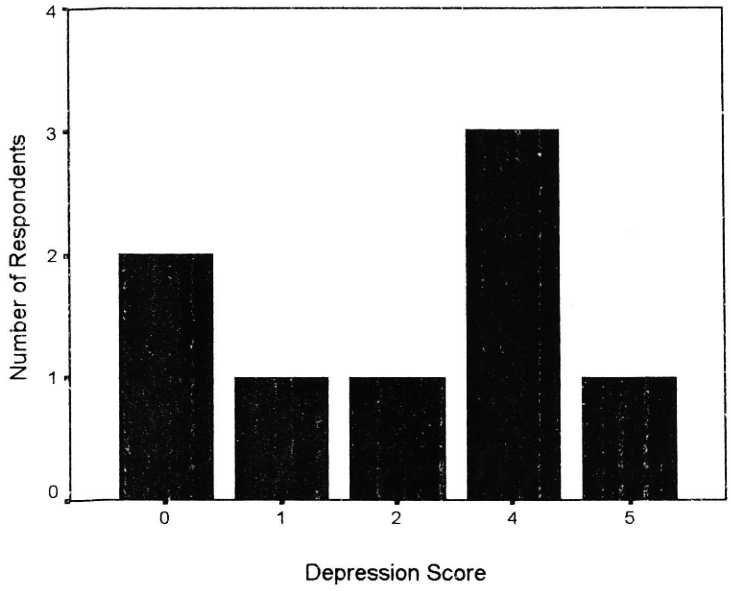
Depression Level of Respondents

As displayed in Figure 5.2, none of the respondents received a score indicating mild clinical depression or clinical depression.

These results are based from the 15 item Geriatric Depression Scale. Respondents with a score of five to nine were considered to be mildly clinically

depressed and a score of ten or higher represents clinical depression and a score of zero to five were indicated by normal (Sheikh & Yesavage, 1986).

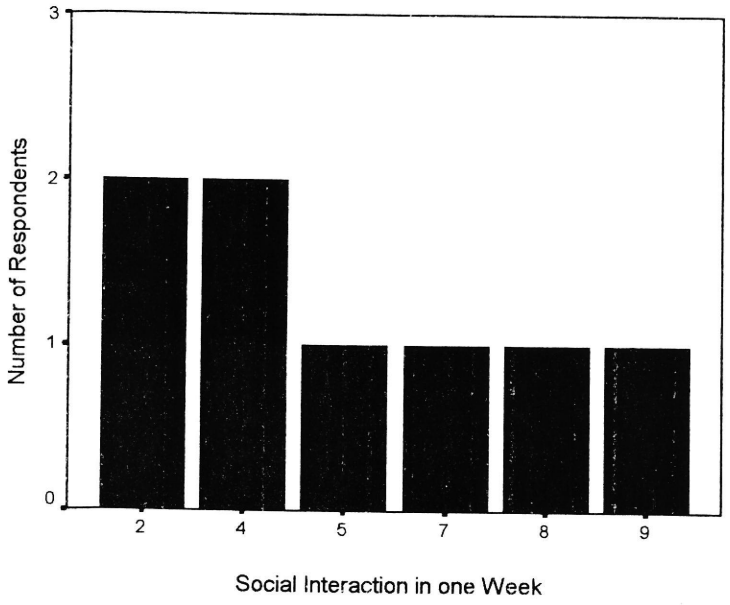
Number 2
Figure 5.2
Depression Level of Respondents
n=8



Social Interaction of Respondents

Figure 5.3 presents the number of social interactions of the eight study participants. Social interaction was measured by questions such as: number of times in the past week they talked with friends or family on the telephone. Other questions in this section related to the number of family members within one hour's travel, time spent with someone they were not living with in the building, and number of times they attended a group meeting.

Number 3
Figure 5.3
Social Interaction of Respondents
n=8



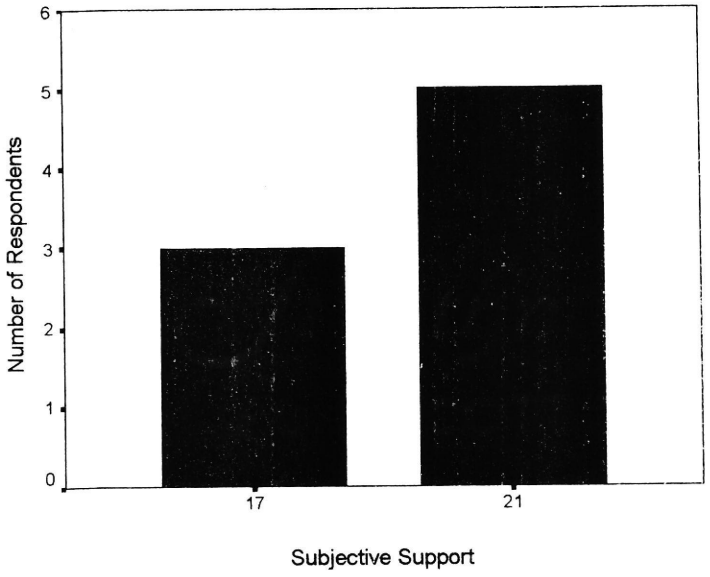
Through these questions, two respondents had at least two contacts with friends or family in the past week, two had at least four contacts, one had five, one had seven, one had eight and one had nine. Individuals who scored three or less were considered to have impaired social interaction (Koening, Westlund, George, Hughes, Blazer & Hybels, 1993). The higher the scale score, the greater the support. The mean score was 5.13 and the standard deviation was 2.64.

Subjective Support

Subjective support was measured by questions such as: Do you feel useful to your family and friends most of the time, some of the time or hardly ever?; Does it seem that your family and friends understand you most of they time, some of the time, or hardly ever?; When you are talking with your family and friends, do you feel you are being listened to most of the time, some of the time, or hardly ever?; and Do you know what is

going on with your family and friends most of the time, some of the time, or hardly ever. The higher the score, the greater the perceived social support as indicated by Koening, Westlund, George, Hughes, Blazer and Hybels (1993). The total of these answers are displayed in Figure 5.4.

Number 4
Figure 5.4
Subjective Support of Respondents
n=8



The highest possible score for subjective support is 21. Five respondents (62.5%), scored 21, while three (37.5%) scored a 17. The designation of a value of 1 was given to respondents who scored a 14 or less (impaired), and a 0 to respondents who scored a 15 and above (not impaired)(Hughes, Blazer, & Hybels, 1990). These scores indicate that there is no impairment within their subjective social support. Subjective support results indicated the mean score to be 19.5 while the standard deviation was 2.07.

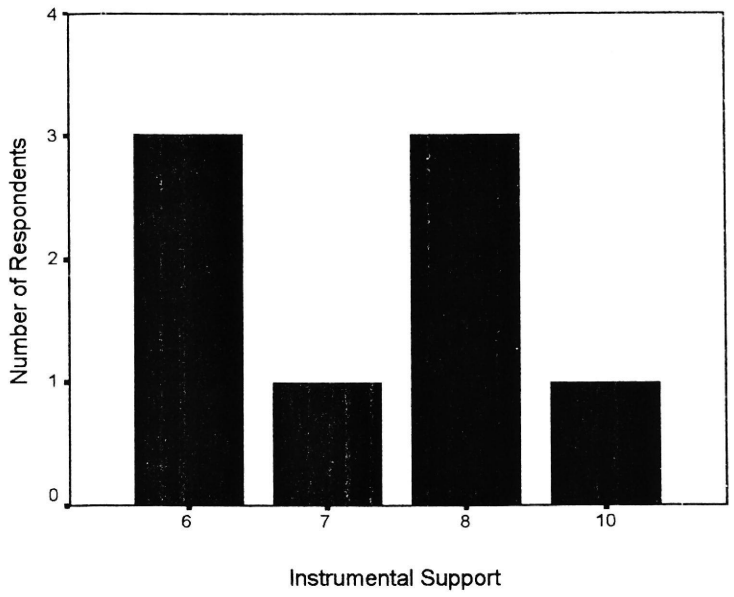
Instrumental Support

In Figure 5.5, the instrumental support of the older adult is displayed. The questions that were asked in the instrumental support section were: Do your family or friends ever help you in the following ways: Help you when you are sick?; Shop or run errands for you?; Help you out with money?; and Fix things around the house. Questions were answered yes, no, refused to answer, do not know, or no answer.

The results of these questions were added together to identify the total scale score. The higher this score, the more help the respondents' report receiving (Hughes, Blazer, & Hybels, 1990).

Number 5
Figure 5.5
Instrumental Support of Respondents

n=8



The results from these questions reflect how dependent the individuals are on family members or friends to have their weekly needs met. Three respondents (40%) felt family provided instrumental support six times a week, while one respondent (10%) felt

family provided support seven times a week. Three respondents (40%) scored an 8, while one respondent (10%), scored a 10 for the weekly instrumental support provided by family and friends. The mean score for this type of support was 7.

Findings for Research Question #1

For the first research question, the study on social support and depression produced mixed results. One respondent's results indicated no relevance in regards to his or her social supports to the level of depression. The respondent's level of social support indicated minimal contact with others, but indicated a level of comfort with his or her mental health, thus producing a normal level of functioning as depicted with the Geriatric Depression Scale (Sheikh & Yesavage, 1986).

One respondent who indicated the highest level of social support scored the highest possible scores within the subsections of instrumental support, subjective support and social interaction in the Duke Social Support Index (Koening, Westlund, George, Hughes, Blazer, & Hybels, 1993). The respondent's answers pertaining to the Geriatric Depression Scale indicated a normal level of functioning, but scored a five out of fifteen with the next level starting at a score of six and described in the Geriatric Depression Scale (Sheikh & Yesavage, 1986).

Findings

The second research question stated the following:

2. What is the availability of social supports provided to the older adults (as perceived by the older adult)?

When respondents answered the questions from the Duke Social Support Index, the results, as presented in Figure 6, indicated high levels of perceived support.

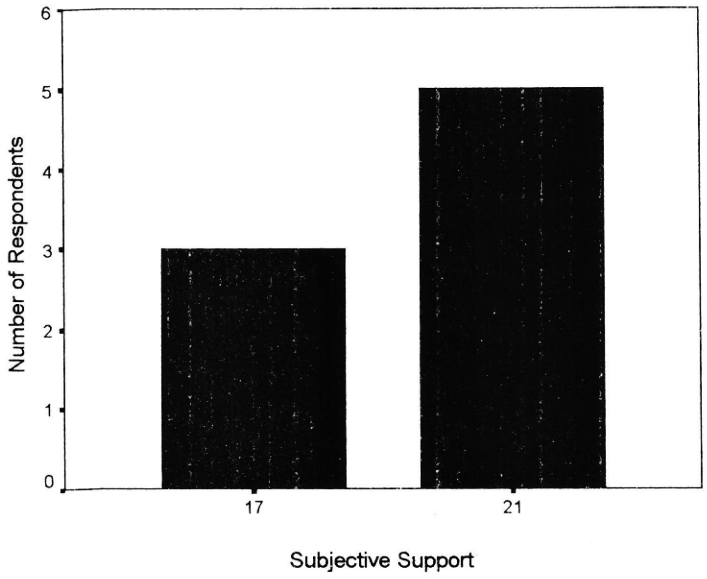
Subjective Support

To examine the availability of social supports as perceived by the older adult, the subsection of subjective support was examined. Subjective support represents how the older adult feels their family or friends make them feel needed or wanted by asking them for advice or assistance.

Subjective support was measured by questions such as: Do you feel useful to your family and friends most of the time, some of the time or hardly ever?; Does it seem that your family and friends understand you most of they time, some of the time, or hardly ever?; When you are talking with your family and friends, Do you feel you are being listened to most of the time, some of the time, or hardly ever?; and Do you know what is going on with your family and friends most of the time, some of the time, or hardly ever.

As stated previously, subjective support is measured through the division of impaired and not impaired. The designation of a value of 1 was given to respondents who scored a 14 or less (impaired), and a 0 to respondents who scored a 15 and above (not impaired)(Hughes, Blazer, & Hybels, 1990). The respondents' answers indicate no impairment.

Number 6
Figure 5.6
Subjective Support of Respondents
n=8

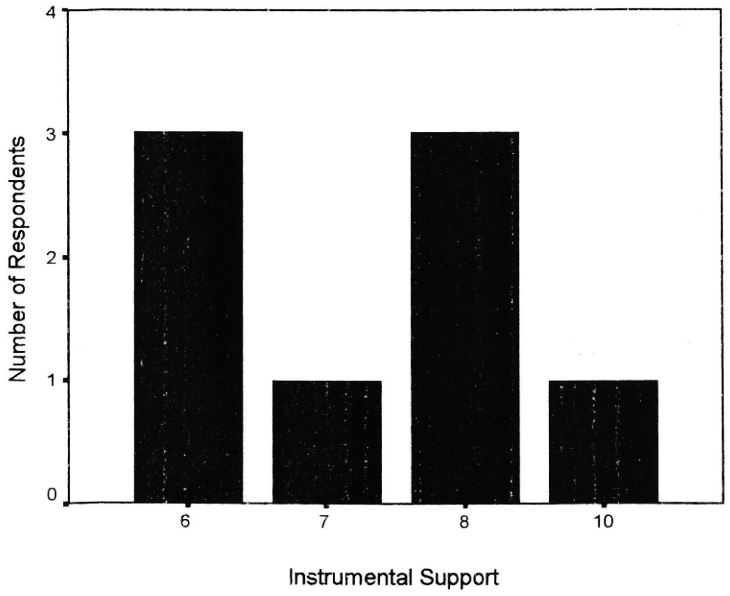


Instrumental Support

Through the measurement of instrumental support, the respondents interviewed indicated their family and friends would be supportive if they needed assistance as seen in Figure 5.7. The questions that were asked in the instrumental support section were, Do your family or friends ever help you in the following ways: Help you when you are sick?; Shop or run errands for you?; Help you out with money?; and Fix things around the house. Questions were answered yes, no, refused to answer, don't know, or no answer.

The results of these questions were added together to identify the total scale score. The higher this score, the more help the respondents' report receiving (Hughes, Blazer, & Hybels, 1990).

Number 7
Figure 5.7
Instrumental Support of Respondents
n=8



Findings from Research Question #2

In regard to the second research question, the Duke Social Support Index suggested a moderate to high level of perceived social support for all the respondents. This was reflected from the findings in Figure 5.6 and Figure 5.7. These results from Figure 5.6 indicate a high level of subjective support. The results from Figure 5.7 indicate a moderate level of instrumental support through the contacts they have with friends and families on a weekly basis. Moderate levels of instrumental support were designated through the mean score of seven. Although the results do not indicate impaired functioning, this research question examined the importance of perceived support as described by the older adults. The respondents interviewed for this research

study indicated the importance of knowing information about their family and how they perceive this information to be supportive.

CHAPTER 6

Discussion

This chapter examines the relevant findings to the research questions, themes, comparison of findings to the theoretical framework, strengths of this study, limitations to this study, implications for practice and policy, and the conclusion and recommendations for future research.

Relevant Findings to Research Questions

This study examined the following questions: what is the relationship between level of social support and depression in older adults in an age segregated housing complex?; and what is the availability of social supports provided to the older adults (as perceived by the older adult)?

Through the completion of the Geriatric Depression Scale, most of the respondents scored a one to a five, thus indicating a normal level of functioning. Respondents discussed the aspect of physical ailments and how these symptoms affected their daily feelings and thoughts. Three of the respondents answered questions connected to the Geriatric Depression Scale, but would continue the response by explaining their physical ailments or a recent argument they had with a friend that would adversely affect their mood.

Respondents discussed how their family members made weekly contact with them, either by phone or by a visit. When family members came to visit, the older adult

felt they understood the extended dynamics of the family and could describe where they felt they fit in.

Themes

Social Support

Participants found support within the housing complex or through their families-immediate or extended-to meet their needs. Respondents felt they had a definite place in their family and knew what was going on within their family. The respondents interviewed expressed strong social supports, suggesting the predictions of findings by Newsom & Schulz (1996); Potts (1997); and Rogers (1999).

Respondents discussed some of their physical ailments. They discussed how their families and friends played an integral part in their current level of happiness. This reflects the findings of Thompson and Krause (1998). The composition of friends and families of individuals living alone became an important aspect of an individual's health conditions as described in Grant, Patterson and Yager's study (1988). The findings of this research study identify the high level of social support for the respondents. Frequent contact diminishes the aspects of poor health.

As found in Mullins's (1991) study, the family and friend relationships solidified the independence and meaning in relationships. This study found that the stronger relationships of the older adult improve the perceived health of the older adult. The respondents in this study discussed the relevance of familial contact on a weekly basis and the importance of contact with friends on a weekly basis, whether these friends were close or identified as acquaintances.

Although one respondent indicated a low level of social support compared to others, this respondent felt confident with the current level of support. The respondent understood and accepted how the aging process would cause a loss in friends and family members. This respondent accepted how death can take family members and friends and has learned how to adjust and cope.

Depression

Typically, symptoms of depression increase as the level of social support decreases. In this study, this was not the case. The respondent with the highest level of social support also had the highest level of depression. On the other hand, the respondent with the lowest level of social support in this study had a reading indicating a normal level of functioning.

The increase of depression in the one of the respondents interviewed indicated that disruptions such as death or the gradual decline in their physical condition caused an increase in social support as also cited from Burnette and Mui (1994). One of the respondents in this study talked intermittently about his or her failing health while completing the Geriatric Depression Scale. This respondent scored a four on the depression score. One of the respondents stated their activity level had decreased and they were unable to complete some of the activities they used to enjoy in the past due to their health conditions. These conditions were also noted in the study completed by Burnette and Mui (1994) that stated that depression levels increased as their health decreases.

The older adult's physical characteristics such as sleep disturbances, decrease in appetite or Alzheimer's disease sometimes relate to symptoms of depression as noted by

Drozdick, Edelstein, Kalish, McKee and Whipple (1999). The reactions to physical or psychological disturbances can be related to the typical signs of depression. As an older adult continues to have complicated health problems, they minimize their mental health needs. All the respondents in this study talked about their health problems intermittently, but never mentioned characteristics in response to their mental health.

Many older adults rely on their family members or local physician for their medical or emotional needs. The respondents expressed how they would rely on their family and medical doctor before searching for a psychiatrist or a mental health worker. In a study conducted by Abraham, Neese, Snustad and Thompson-Heisterman (1993), along with a second study conducted by Klenow and Robke (1998), they identified the lack of routine contact with the older adults and the lack of knowledge on the part of the older adult reflects their search for services if they were needed.

Comparison of Findings to the Theoretical Framework

The general systems theory used in this study identifies how the families play an integral part in the level of social support perceived by the older adult. The respondents of this study felt confident with contacts they had and felt accepted within their family and friends.

The respondents' social network may exercise a positive influence on the physical and emotional well being of the older adults. The support provided by friends and family consist of providing transportation, advice, financial assistance, companionship and additional help with the respondents' activities of daily living to slow down or prevent the deterioration of the health status as found in the study conducted by Ell (1984). This study identified the instrumental support provided to the older adult reflects how their

perception of social supports increases. The scores within the instrumental support scale indicate the increase in support provided by family and friends in a weekly basis ranges from six to ten interactions of support on a weekly basis. As these interactions increase, the perceived social support become a reality in understanding their effectiveness.

With the use of the Duke Social Support Index, the social support of the respondents indicated a high level of dependency on family or friends to meet their needs on a weekly basis. Through the social support theory, the continuous or intermittent contact with family and friends increases their physical and emotional integrity as proved by Caplan (1974).

Strengths of this Study

The major strength of this study relates to the willingness of the respondents interviewed. They answered the questions objectively and also provided additional information to support their answers. The answers were quantitative in nature. This provided a statistical measurement of their answers and a general analysis of the way they interact with others and how this may correspond to their depression levels. The information provided by this study creates an alternative way of examining depression and social support using two instruments. These instruments have not been combined in the past with an older adult population under 35,000 in the Midwest. Additional studies could be created to examine the further effectiveness of these combined tools in any environment.

Limitations of this Study

One limitation is the distribution of the envelopes to potential respondents. The postcard was to be sent back by May 1, 2001, but due to the schedule of the apartment

manager and the researcher, the potential respondents did not receive the envelopes until two days before the due date. The apartment manager informed these potential respondents verbally that they could return the postcard up to May 5th, but this did not increase the return rate. Most of the respondents did not know who the researcher was personally so there may have been some insecurity in having a stranger come into their home and asking them personal questions.

The interviews for this study were completed one week after Mother's Day. Even with the researcher informing participants that they should not count any phone calls or contacts due to this holiday, some of the older adults may have counted this additional support. Interactions following or proceeding Mother's Day may result in inaccurate data due to their increased interactions and support provided my friends and family members.

In one situation, the respondent knew members of the researcher's extended family and was willing to participate only because of the researcher's family and the further questions they wanted to ask to the respondent. In another situation, the respondent had a close friend within the building that has had frequent contact with the researcher and was encouraged by the close friend to participate due to his or her own knowledge of the researcher. Systematically, these measurement errors may have altered the answers of the older adults. These respondents may have answered the questions in order to impress the researcher, minimize their depression level, or alter their answers on social supports in order to seek approval from the researcher.

The results of this study cannot be generalized to the entire housing complex. With a participation rate of only 20%, the results do not provide a thorough explanation

of the respondents. The results also cannot be generalized to other existing housing complexes in the Midwest.

The respondents who replied to this study did not indicate any high levels of depression. As identified in this research study, the high level of social supports of the respondents interviewed indicated his or her perceived depression level to be lower. The general need of the older adult population cannot be generalized with the study results.

One limitation in this study is the sample size. With only eight older adults interviewed, the findings cannot be generalized to the entire population of this housing complex, it will not present data that can be attributed to the other apartments in this Midwest town.

In a rural community, gaining the trust of the respondents is important. Through the application process at Augsburg College Institutional Review Board, the respondents would be contacted through a letter and a return postcard distributed by the Apartment manager. This contact may not provide the necessary trust older adults in a rural community need before participating in any form of a survey. Infiltration approaches may be necessary to gain credibility with older adults. These approaches are necessary to gain cooperation and an effective exchange of information (Patton, 1987). In this study, the proposed plan for contact was door-to-door conversations. Due to the invasiveness of this approach, it was altered to a formal letter with response card as suggested by the Augsburg College Institutional Review Board.

Other limitations include: geographic location, lack of ethnic and racial diversity, and marital status. The sample selection was intentional; the respondents were selected because this writer wanted to identify the social supports of older adults living alone in a

Caucasian, rural community. Efforts by previous researchers examined older adults in cities with a population over 50,000, or individuals who reside in their own home in a rural setting or in an urban setting.

Implications for Practice and Policy

The implications for this study to practitioners who work with older adults would be to increase their search for finding effective social supports reduces the likelihood of depression for older adults. The practitioners would first have to identify the older adult who may be depressed or lack a strong social network. This would be achieved through the effective assessment skills in understanding symptoms relating to depression and decreased social supports. Questions they need to examine are, does the disrupted sleep patterns faced by an older adult relate to their depression, a physical ailment, or by choice of the older adult? Does the decrease in social contacts reflect a recent argument, or does it reflect a decrease in the social support due to death or separation through relocation? How can an older adult with low social supports still maintain a healthy outlook on life or have a high level of depression with a high level of social supports? After understanding how to effectively work with a diverse population of older adults with many different needs, the practitioner can focus on finding the necessary resources an older adult needs to survive.

This research study examined one apartment complex in the Midwest. Extensive research using the identified questions above, may improve the results of any future studies. Through a closer examination of income, education, and disruptions within their social support, a practitioner can create an effective assessment tool in working with the older adult population.

In order to be completely effective, the practitioner needs to educate policy makers in understanding the importance of volunteer programs and other supplemental resources used by the older adult to sustain a healthy lifestyle. These resources include financial, home health services, visiting volunteer programs, senior centers, and supplemental funds provided to age segregated housing complexes for activities and trips. With current financial situations within our government, an understanding of how the financial cuts made to our older adult population affects their emotional and physical well being needs to be examined to find supportive information about the effectiveness of programs to keep individuals at home longer. As a practitioner, it would be essential to educate the community about the ongoing needs of the older adults. Providing for public speaking venues at churches, local agencies or local clubs may increase the community involvement in the lives of older adults with few social supports. By acting as an advocate and a broker for the older adults they serve, effective ways are created for additional assistance for an older adult who lacks the social supports to maintain healthy relationships or for an individual who is developing symptoms of depression.

This research study did not identify the services the older adult received. The relationship between this research study and activities such as lobbying for services and identifying effective services used by the older adult will enable practitioners to focus on what needs to be accomplished. Current policies can be created through effective research studies to develop or redesign programs for older adults.

Conclusion and Recommendations for Future Research

This research study was completed to examine if there was a relationship between the level of social support o the level of depression or if the availability of social support

affect their perceptions of support. This research study indicated that the older adult with supportive relationships maintained a healthier lifestyle. This research study also examined how the level of social support does not influence the emotional well being of the older adult if their support is sporadic or argumentative. All of the individuals interviewed maintained a healthy relationship with at least one family member or one close friend with whom they felt they could share anything.

Further research could be conducted using these scales in metropolitan areas or in other rural areas. A representation of culturally diverse respondents may affect the results of these scales. A further examination of the relationship between these two scales throughout differing locations in a community. Other areas needing further attention include the differences between men and women, the educational background of participants, their knowledge of local resources, and their financial status.

The level of awareness of the practitioners for further education about the different signs or symptoms of depression is an important aspect to examine. The practitioner has direct contact with individuals who may seek help for daily needs, but recognize other aspects of the individual's life where they may need assistance. Public relations with older adults need to improve. Communities need to be educated about the importance of taking care of their older adults, through phone contacts, visits, or assisting with minor daily needs. Through the education of practitioners and communities, the older adults needs will gradually be met to improve their mental health and physical well-being.

In order to effectively reach older adults in a rural setting, infiltration methods may need to be used in order to gain the desired population (Patton, 1987). By talking to

the older adult at their daily gatherings or monthly meetings, the researcher may become credible and establish rapport with respondents. In a rural setting, it is important to get close to the individuals being studied to develop confidentiality and a sense of shared experiences. An examination of effective methods of reaching older adults should be completed in order to understand what approach would be the most effective.

References

Abraham, I., Neese, J. B., Snustad, D. G., & Thompson-Heisterman, A. A. (1993). Mental health outreach to rural elderly: Service delivery to a forgotten risk group. Clinical Gerontologist, 14(1), 95-111.

Adams, R. G. (1985-86). Emotional closeness and physical distance between friends: Implications for elderly women living in age-segregated settings. International Journal of Aging and Human Development, 22(1), 55-75.

Adamson, D., Caserta, M., Feinauer, L., & Lund, D. (1992). Factors affecting marital happiness of caregivers of the elderly in multigenerational families. The American Journal of Family Therapy, 20(1), 62-70.

Allen, N. B., Lewisohn, P. M., Roberts, R. E., & Seeley, J. R. (1997). Center for Epidemologic Studies Depression Scale (CES-D) as a screening instrument for depression among community-residing older adults. Psychology and Aging, 12(2), 277-287.

Barker, R. L. (1995). The social work dictionary (3rd ed.). Washington D.C.: NASW Press.

Bernstein, M. D., & Stephens, M. P. (1984). Social support and well-being among residents of planned housing. The Gerontologist, 24(2), 144-148.

Bijur, P. E., Kelman, H. R., Kennedy, G. J., Metz, H., Thomas, C., & Wisniewski, W. (1989). Hierarchy of characteristics associated with depressive symptoms in an urban elderly sample. American Journal of Psychiatry, 146(2), 220-225.

Black, B. S., German, P., McGuire, M., Rabins, P. V., & Roca, R. (1997). Need and unmet need for mental health care among elderly public housing residents. The

Gerontologist, 37(6), 717-728.

Blazer, D. G. (1982). Social support and mortality in an elderly community population. Journal of Epidemiology,115, 684-694.

Bookwala, J., Newsom, J. T., & Schulz, R. (1997). Social support measurement in group residences for older adults. Journal of Mental Health and Aging, 3(1), 47-66.

Burnette, D., & Mui, A. C. (1994). Determinants of self reported depressive symptoms by frail elderly persons living alone. Journal of Gerontological Social Work, 22(1/2), 3-19.

Caplan, G. (1974). Social systems and community mental health: Lectures on concept development. New York: Behavioral Publications.

Carner, E. A., Klein, M., & Waxman, H. M. (1984). Underutilization of mental health professional by community elderly. The Gerontologist, 24(1), 23-29.

Deeg, D. J., Ferrucci, L., Guralnik, J. M., Penninx, W. J., Simonsick, E. M., & Wallace, R. B. (1998). Depressive symptoms and physical decline in community-dwelling older persons. JAMA, The Journal of the American Medical Association, 279(21), 1720-1727.

DeJong, C.R., Monette, D. R., & Sullivan, T.J. (1994). Applied social research. Chicago, Il: Hardcourt Brace.

Drozdick, L. W., Edelstein, B., Kalish, K. D., & McKee, D. R. (1999). Handbook of assessment in clinical gerontology. New York, NY: John Wiley & Sons, Inc.

Ell, K. (1984). Social networks, social supports, and health status: A review. Social Science Review, 58, 133-149.

Fukunishi, I., Aoki, T., & Hosaka, T. (1997). Correlations for social support with

depression in the chronic poststroke period. Perceptual and Motor Skills, 85, 811-818.

Grant, I. G., Patterson, T. L., & Yager, J. (1988). Social supports in relation to physical health and symptoms of depression in the elderly. American Journal of Psychiatry, 145(10), 1254-1257.

Harman, J. S., & Reynolds III, C. F. (2000). Removing the barriers to effective depression treatment in old age. Journal of the American Geriatric Society, 48(8), 1012-1013.

Hernandez, N. A., Hinrichsen, G. A., & Lapidus, L. B. (1998). An empirical study of object relations in adult children of depressed elderly mothers. International Journal of Aging and Human Development, 46(2), 143-156.

Hughes, D. C., Blazer, D., & Hybels, C. (Ed.). (1990, April). Duke Social Support Index (DSSI). (Available from the Center for the Study of Aging and Human Development, Duke University Medical Center, Box 3875, Durham, NC 27710).

Hyduk, C. A. (1996). The dynamic relationship between social supports and health in older adults: Assessment implications. Journal of Gerontological Social Work,27(1/2), 149-165.

Jenkins, M. A., Salloway, S., & Westlake, R. (1996). The diagnosis and treatment of geriatric depression. Journal of Praticing Psychiatry and Behavioral Health, 336-348.

Kavan, M. G., Pace, T. M., Panterotto, J. G., & Barone, E.J. (1990). Screening for depression: Use of patient questionnaires. American Family Physician, 41(3), 897-905.

Klenow, D. J., & Rokke, P. D. (1998). Prevalence of depressive symptoms among rural elderly: Examining the need for mental health services. Psychotherapy, 35(4), 545-

558.

Koening, H. G., Westlund, R. E., George, L. K., Hughes, D. C., Blazer, D.G., & Hybels, C. (1993). Abbreviating the Duke Social Support Index for use in chronically ill elderly individuals. Psychosomatics, 34 (1), 61-69.

Krause, N., & Markides, K. (1990). Measuring social support among older adults. International Journal of Aging and Human Development, 30, 37-53.

Maguire, L. (1991). Social support systems in practice: A generalist approach. Silver Spring, MD: NASW Press.

Mullins, L. C. (1991). Loneliness: Its effects on older persons in congregate housing. SSR, 75,(3), 170-178.

Mullins, L. C., & Dugan, E. (1990). The influence of depression, and family and friendship relations, on residents' loneliness in congregate housing. The Gerontologist, 30 (3), 377-383.

Murrell, S. A., & Phillips, M. A. (1994). Impact of psychological and physical health, stressful events, and social support on subsequent mental health help seeking among older adults. Journal of Consulting and Clinical Psychology, 62, 270-275.

Newsom, J. T., & Schulz, R. (1996). Social support as a mediator in the relation between functional status and quality of life in older adults. Psychology and Aging, 11(1), 33-44.

Patton, M. Q. (1987). How to use qualitative methods in evaluation. Newbury Park, CA: Sage Publications.

Payne, M. (1997). Modern social work theory. (2nd ed.). Chicago, IL.: Lyceum Books, Inc.

Potts, M. K. (1997). Social support and depression among older adults living alone: The importance of friends within and outside of a retirement community. Social Work, 42(3), 348-362.

Reynolds III, C. F. (1995). Recognition and differentiation of elderly depression in the clinical setting. Geriatrics, 50(SUPP), S6-16.

Rogers, A. (1999). Factors associated with depression and low life satisfaction in the low-income, frail elderly. Journal of Gerontological Social Work, 31(1/2), 169-196.

Seeman, T., Kaplan, G., Knudsen, L., Cohen, R., & Guralnik, J. (1987). Social network ties and mortality among the elderly in the Alameda County study. American Journal of Epidemiology,126(4), 714-725.

Sheehan, N. W. (1986). Informal support among the elderly in public senior housing. The Gerontologist, 26(2), 171-175.

Sheikh, J.I., & Yesavage, J. A. (1986). Geriatric Depression Scale: Recent evidence and development of a shorter version. Clinical Gerontologist,5, 165-172.

Stolar, G. E., MacEntee, M. I., & Hill, P. (1993). The elderly: Their perceived supports and reciprocal behaviors. Journal of Gerontological Social Work, 19(3/4), 15-33.

Thompson, E. E., & Krause, N. (1998). Living alone and neighborhood characteristics as predictors of social support in late life. Journal of Gerontology: Social Sciences, (53B), 6, S354-S364.

Turner, F. J. (1996). Social work treatment. (4th ed.). New York: The Free Press.

Wallsten, S. M., Tweed, D. L., Blazer, D. G., & George, L. K. (1999). Disability and depressive symptoms in the elderly: The effects of instrumental support and its subjective appraisal. International Journal of Aging and Human Development, 48(2), 145-159.

APPENDIX A

Permission Letter from Housing Complex

March 1, 2001

Erica Doyen
P.O. Box 4254
Mankato, MN 56002-4254

Dear Erica:

Thank-you for your interest in conducting your social work masters thesis research study for Augsburg College here at . Your topic, social support and depressive symptoms of older adults residing in an age segregated housing complex, is an area that deserves attention. I would be willing to accept your proposal in conducting your research study here with a signed consent form completed by the resident.

As we had discussed, a systematic sample of the residents will be done to choose thirty residents to interview. The use of one floor to pre-test your questionnaire is permissible. The honorarium of two dollars is acceptable and would be an incentive for the residents at to complete your study.

If you have any questions, please don't hesitate to call.

Sincerely,

Joyce Borneke

Joyce Borneke
On-Site Manager

APPENDIX B

Letter Sent to Respondents

April 24, 2001

Dear Resident:

You are invited to be in a research study examining social support and your current mood in an age segregated housing complex. You were selected as a possible participant because you are over the age of 55 and currently live alone. This study is being conducted by: Erica Doyen as part of her Social Work master's thesis at Augsburg College.

The records of this study will be kept private. In any sort of report I might publish, I will not include any information that will make it possible to identify you. Research records will be kept in a locked file; only my thesis advisor and myself will have access to the records. Raw data will be destroyed by December 31, 2001.

Your decision whether or not to participate will not affect your current or future relations with the College or with Erica Doyen. If you decide to participate, you are free to withdraw at any time without affecting those relationships.

The researcher conducting this study is Erica Doyen. If you have questions, you may contact Erica at her pager number of 386-5149. Or contact my thesis advisor, Professor Sharon Patten at (612) 330-1723.

If you would like to participate, please mail the post card no later than May 1, 2001.

Sincerely,

Erica M. Doyen, LSW

APPENDIX C

Confidentiality Form

Confidentiality Form

You are invited to be a participant in a research study examining social support in an age segregated housing complex. You were selected as a possible participant because you are over the age of 55 and currently live alone. I ask that you read this form and ask any questions you may have before agreeing to this study. Your participation is completely voluntary. This research study is being conducted by Erica Doyen in partial fulfillment of the Master of Social Work thesis requirement at Augsburg College.

Background Information:

The purpose of this study is to examine the social supports of the older adult.

Procedures:

This study will take about 30 minutes to complete. I am a student working on my Masters degree in Social Work at Augsburg College. I am currently working on my thesis and I will conduct the interview. You will be asked to answer questions regarding social supports. After the interview is complete, I will compile all the information you gave me to create a statistical analysis of your relationship with social supports. The only contact we will have together is through the completion of this survey. If you have any questions before, during, or after this survey, please contact me and I will answer questions you may have regarding this survey.

Risks and Benefits of Being in the Study:

The study has several risks: First, it may bring up hurtful feelings you may have about your friends or family. Second, it may feel like an invasion of privacy into personal information. If at any point during the interview you feel uncomfortable, you may stop the interview without consequence.
If you do not want to answer a question, we can skip this question and I will proceed in asking you the next question. After completing this interview, the following counseling referrals are available if a need would arise:
First Call for Help 1-800-543-7709
Immanuel St. Joseph Hospital Behavioral Health 345-2620

Benefits:

There are a few possible benefits:

1). An awareness of your current social support and benefits;
2). You may enjoy the interview or spending time with me;
3). You may increase your knowledge of the social work profession;
4). An increased awareness of the purpose of research. You will receive an honorarium, a gold dollar coin, whether or not you complete the interview.

Where interviews will be done:

After the consent form has been signed, the interview will follow. The interview will be conducted in your apartment.

Confidentiality:

The records of this study will be kept private. In any sort of report I might publish, I will not include any information that will make it possible to identify you. Research records will be kept in a locked file; only the researcher will have access to the records.

Raw data will be destroyed by December 31, 2001.

Voluntary Nature of the Study:

Your decision whether or not to participate will not affect your current or future relations with Augsburg College or with Gus Johnson Plaza. If you decide to participate, you are free to withdraw at any time without affecting those relationships. If you withdraw early from this study, you will still receive the gold dollar coin for your efforts.

Contacts and Questions:

The researcher conducting this study is Erica Doyen. You may ask any questions you have now. If you have questions later, you may contact me at 386-5149,which is my pager number. You can leave me a message at this number and I will contact you as soon as I can. Or contact my thesis advisor, Professor Sharon Patten at (612) 330-1723.

You will be given a copy of the form to keep for your records if you would like one.

Statement of Consent:

I have read the above information. I have asked questions and have received answers. I consent to participate in the study.

Signature _____ Date _____

Signature of Investigator _____ Date _____

APPENDIX D

Interview Guide

My name is Erica Doyen and I am currently working on my masters degree at Augsburg College. If at any time you feel uncomfortable answering these questions, we can stop the interview at any time.

Gender Male Female

Current Marital Status: Never Married Married
Divorced Separated
Widowed

What is your birth date? ____/____/____

Now I'd like to talk with you about your family and friends.

4. Other than members of your family, how many persons in this area within one hour's travel (of your home/from here) do you feel you can depend on or feel very close to?

   Number _____ _____

   NONE.....00
   REFUSED.....97
   DON'T KNOW 98
   NO ANSWER.....99
   RECODE VALUES
   0=0
   1-5 OR 96=1
   6-10=2
   11-20=3
   21 OR HIGHER=4

5. How many times during the past week did you spend some time with someone who does not live with you, that is, you went to see them or they came to visit you, or you went out together?

   00=Not at all
   01=Once
   02=Twice
   03=Three times
   04=Four times
   05=Five times
   06=Six times

   RECODE VALUES
   0=0
   1-2=1
   3-4=2
   5 OR HIGHER=3

07=Seven times or more
97=REFUSED
98=DON'T KNOW
99=NO ANSWER

6. How many times did you talk to someone—friends, relatives or others—on the telephone in the past week (either they called you, or you called them)?

00=Not at all
01=Once
02=Twice
03=Three times
04=Four times
05=Five times
06=Six times
07=Seven times or more
97=REFUSED
98=DON'T KNOW
99=NO ANSWER

RECODE VALUES
0=0
1-2=1
3-4=2
5 OR HIGHER=3

7. About how often did you go to meetings of clubs, religious meetings, or other groups that you belong to in the past week?

00=Not at all
01=Once
02=Twice
03=Three times
04=Four times
05=Five times
06=Six times
07=Seven times or more
97=REFUSED
98=DON'T KNOW
99=NO ANSWER

RECODE VALUES
3 0R HIGHER=3

11. Does it seem that your family and friends understand you most of the time, some of the time, or hardly ever?

1=Hardly ever
2=Some
3=Most
7=REFUSED
8=DON'T KNOW
9=NO ANSWER

13. Do you feel useful to your family and friends most of the time, some of the time, or hardly ever?

    1=Hardly ever
    2=Some
    3=Most
    7=REFUSED
    8=DON'T KNOW
    9=NO ANSWER

14. Do you know what is going on with your family and friends most of the time, some of the time, or hardly ever?

    1=Hardly ever
    2=Some
    3=Most
    7=REFUSED
    8=DON'T KNOW
    9=NO ANSWER

15. When you are talking with your family and friends, do you feel you are being listened to most of the time, some of the time, or hardly ever?

    1=Hardly ever
    2=Some
    3=Most
    7=REFUSED
    8=DON'T KNOW
    9=NO ANSWER

16. Do you feel you have a definite role (place) in your family and among your friends most of the time, some of the time, or hardly ever?

    1=Hardly ever
    2=Some
    3=Most
    7=REFUSED
    8=DON'T KNOW
    9=NO ANSWER

18. Can you talk about your deepest problems with at least some of your family and friends most of the time, some of the time, or hardly ever?

    1=Hardly ever
    2=Some
    3=Most
    7=REFUSED
    8=DON'T KNOW
    9=NO ANSWER

19. How satisfied are you with the kinds of relationships you have with your family and friends—very dissatisfied, somewhat dissatisfied, or satisfied?

    1=Very dissatisfied
    2=Somewhat dissatisfied
    3=Satisfied
    7=REFUSED
    8=DON'T KNOW
    9=NO ANSWER

1. Are you basically satisfied with your life?	YES	**NO**
2. Have you dropped many of your activities and interests?	**YES**	NO
3. Do you feel that your life is empty?	**YES**	NO
4. Do you often get bored?	**YES**	NO
5. Are you in good spirits most of the time?	YES	**NO**
6. Are you afraid that something bad is going to happen to you?	**YES**	NO
7. Do you feel happy most of the time?	YES	**NO**
8. Do you often feel helpless?	**YES**	NO
9. Do you prefer to stay at home, rather than going out and doing new things?	**YES**	NO
10. Do you feel you have more problems with memory than most?	**YES**	NO
11. Do you think it is wonderful to be alive now?	YES	**NO**
12. Do you feel pretty worthless the way you are now?	**YES**	NO
13. Do you feel full of energy?	YES	**NO**
14. Do you feel that your situation is hopeless?	**YES**	NO
15. Do you think that most people are better off than you are?	**YES**	NO

Answers in **bold** indicate depression. Although differing sensitivities and specificities have been obtained across studies, for clinical purposes a score > 5 points is suggestive of depression. Scores > 10 are almost always depression.

Now I want to ask you about some of the ways your family and friends help you out. Do your family or friends ever help you in any of the following ways:

For Questions 20-31:
Recode Values 1=0
2=1

REPEAT FOR EACH QUESTION: Do they...	**No**	**Yes**	**RF**	**DK**	**NA**
20. Help you out when you are sick?	1	2	7	8	9
21. Shop or run errands for you?	1	2	7	8	9
22. Give you gifts (presents)?	1	2	7	8	9
23. Help you out with money?	1	2	7	8	9
24. Fix things around your house?	1	2	7	8	9
25. Keep house for you, or do household chores?	1	2	7	8	9
26. Give you advise on business or financial matters?	1	2	7	8	9
27. Provide companionship to you?	1	2	7	8	9
28. Listen to your problems?	1	2	7	8	9
29. Give you advise on dealing with life's problems?	1	2	7	8	9
30. Provide transportation to you?	1	2	7	8	9
31. Prepare or provide meals for you?	1	2	7	8	9

Thank you for your assistance.

APPENDIX E

Script

Script used by the principal investigator

Hi. My name is Erica Doyen and I am a student at Augsburg College working on my Masters degree in Social Work. As part of our program requirements, we must complete a thesis in an area of interest. I am interested in learning more about the social supports of the older adult residing in an age segregated housing complex.

The process requires a thirty-minute interview in which I will ask you several questions. Participation in this study is completely voluntary. There are a few possible indirect benefits: 1). An awareness of your current social support and benefits; 2). You may enjoy the interview or spending time with me; 3). You may increase your knowledge of the social work profession; 4). An increased awareness of the purpose of research. You will receive an honorarium, two dollars, whether or not you complete the interview.

Let me explain to you what a consent form is. A consent form permits me, the researcher, the right to use the information you give me to tabulate results about people who reside in this housing complex. To ensure confidentiality of each participant, I will destroy all the information gathered through the interview when I have finished my study and paper. If you feel uncomfortable during the interview, we can stop at anytime. At any time, a question can be skipped if you feel uncomfortable answering it. After signing this form, I will conduct the interview.

APPENDIX F

Approval Letter from IRB

AUGSBURG

C•O•L•L•E•G•E

MEMORANDUM
TO: Erica M. Doyen MD
FROM: Maria Dinis, Ph.D., Co-Chair
RE: YOUR RECENT IRB APPLICATION
DATE: 20 April 2001

I am writing on behalf of the College's Institutional Review Board on the Use of Human Subjects. Your proposed study, "Social Support and Depressive Symptoms in Older Adults in an Age-Segregated Housing Complex" has been approved. Your IRB approval number is 2001-31-1. Please use this number on all-official correspondence and written materials relative to your study.

The IRB committee wishes you the best in your research.

cc: Professor Sharon Patten, Ph.D., IRB Co-Chair and Advisor

DEPARTMENT OF SOCIAL WORK
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